Table 1: Examples of PDSA Cycles for Quality Improvement Activities to Address Elements of the Chronic Care Model	
Clinical Information Systems	*Examples of PDSA Cycles* • Used registry to disseminate current care guidelines • Used registry reports as performance feedback for providers • Developed registry to track clinical measures and to identify patients who need increased care • Used registry to pre-plan visits, such as pre-scheduling blood work • Identified patients needing diabetes education *Especially innovative PDSA Cycles* • Made registry accessible to physicians via the Internet • Generated pre-addressed letters from the registry for patients with elevated A1C levels • Linked registry to communitywide electronic medical record
Delivery System Design	*Examples of PDSA Cycles* • Implemented planned visits, group visits, and/or chronic disease visits • Revised team roles using questionnaires and team meetings • Involved nurse educators in planned diabetes visits • Posted notices in exam rooms for patients with diabetes to remove shoes • Used registry monthly reports and pop-up reminders for follow-up and care planning • Implemented telephone follow-up *Especially Innovative PDSA Cycles* • Increased number of diabetes educators by using a "train the trainer" approach • Implemented telemedicine for patients living in rural areas • Assigned a health care coach – who was responsible for foot exams and poorly controlled patient referrals – to clustered clinics • Staff phoned no-show clients; if no response on third call, staff visited the client's home • Identified smokers and immediately provided cessation materials
Community	*Examples of PDSA Cycles* • Designated case managers to refer patients to community resources • Sponsored education fairs at regional hospitals, senior centers, etc. • Enabled staff to participate on community boards and task forces • Publicized free pool use at community parks • Worked with community centers to raise money for local ADA walk • Educated faith communities about diabetes management • Disseminated diabetic resources list and education materials to Mall Walker's Club *Especially Innovative PDSA Cycles* • Provided links to wellness and self-development courses such as a GED program, a nutritional course, and a smoking cessation class • Helped staff the "Health-To-Go" van, which provided glucose testing and patient education materials

	• Helped organize clinics, education, and meal design/preparation for the homeless • Created an interactive website for seniors in the community
Decision Support	*Examples of PDSA Cycles* • Developed chronic disease flow sheet that incorporates clinical guidelines • Applied specialist referral guidelines • Generated regular feedback for clinical team on patient outcomes using registry data • Educated providers and staff at grand rounds, in-services, monthly training sessions • Distributed pocket cards listing standards of care/care protocols, numbers-at-a-glance *Especially Innovative PDSA Cycles* • Used electronic chart review and feedback from endocrinologist • Posted guidelines on the Internet • Created informational posters for exam rooms
Self-Management	*Examples of PDSA Cycles* • Tested or adapted self-management assessments and surveys • Created self-management tool kit, which included tracking forms, posters, calendars, action plans, websites, and reading lists • Implemented patient goal-setting forms and collaborative goal setting • Phoned or sent patients support letters • Trained and educated staff in self-management support • Held peer support group meetings • Provided loaner blood glucose self-monitoring materials free of charge *Especially Innovative PDSA Cycles* • Televised self-management course to six counties • Distributed Spanish-language or low-literacy self-management materials • Offered self-management materials to providers via the Internet • Linked individual patient goal setting to the registry • Asked dentists to set patient goals • Used “picture” goal sheets • Provided homeless clients with a card about the signs of hypoglycemia to help them receive food at shelters • Publicized a phone information line staffed by dentists and educators • Offered incentives such as t-shirts to encourage patient completion of self-management activities
Organizational Support	**Organizational Support** *Examples of PDSA Cycles* • Secured financial support for patient education and new efforts • Recruited senior leaders to serve as members of the collaborative team or evaluators of the program

	• Dedicated new employee time to changes • Distributed monthly newsletter from the medical director to providers *Especially Innovative PDSA Cycles* • Formed a chronic care department • Discussed use of the Chronic Care Model with payers • Developed a business plan for the regional diabetes center